CALIFORNIA HEALTHCARE ASSOCIATION

Providing Leadership in Health Policy and Advocacy

CALIFORNIA HEALTHCARE ASSOCIATION
STATEMENT ON
HEALTH AND HUMAN SERVICES
BEFORE THE
CALIFORNIA PERFORMANCE REVIEW COMMISSION
U.C. SAN DIEGO
AUGUST 20, 2004

The California Healthcare Association (CHA), the statewide organization that represents California's hospitals, is pleased to present testimony on the CPR recommendations regarding health and human services. We recognize this is only the first step in what will be a thorough analysis and full debate on the recommendations, and we look forward to participating in this public process.

The CPR recommendations are an important first step in making the delivery of health care in California more effective, efficient and responsive. CHA endorses the CPR effort and many of the health care proposals.

However, we are concerned that some of the recommendations appear to have been developed with input from only a narrow group of stakeholders and therefore may create unintended consequences; some recommendations may not always represent the views of a broader, more representative group of stakeholders and affected persons. As we work together to improve California's health care delivery system, we must be certain not to allow the CPR process to promote questionable public policies. We are pleased the CPR Commission has solicited comments from a broad range of representative stakeholders, such as CHA.

HHS 02

Realigning the Administration of Health and Human Services Programs

CHA is still evaluating the recommendations contained in this section. The California Health and Human Services Agency's stated goal of maintaining access to care depends on adequate funding for the affected populations (—Medically Indigent Adults (MIA), In-Home Supportive Services, Community Medi-Cal Mental Health and Child Welfare Services—), whether services are the responsibility of the state or local entities.

CHA supports the formation of a workgroup to allow proper evaluation and study of this issue. It is imperative, however, for the workgroup to include not only state and county representatives, but health care (hospital) providers, as well. A workgroup of this makeup will ensure that the realignment proposal will delineate accountability for pro-

gram outcomes, appropriate utilization of scarce resources, and implement effective administrative oversight. Additionally, we support in concept, "federalizing" the MIA population by including it in Medi-Cal in order to obtain federal financial participation. We support rate increases to ensure appropriate access to care for this population.

Additional Recommendation — Institutes for Mental Disease (IMD) Exclusion
Currently, federal Medicaid law and regulation prohibit the state from claiming federal financial participation (FFP) for care under the Medicaid program for inpatient psychiatric services provided to residents aged 21 to 64 in private psychiatric hospitals. This IMD exclusion has a significant impact on access and delivery of services to consumers.

In the past, California has expressed its belief that federal policy is inconsistent and Medicaid law and interpretation of that law does not conform to current medical understanding regarding the nature of mental illness. CHA recommends California urge Congress and the Administration to revisit the IMD exclusion policy and provide comparable health care under Medicaid to all beneficiaries, regardless of the patient's age or diagnosis.

The acute inpatient capacity for patients with mental illness is shrinking rapidly, primarily due to the nurse-to-patient ratios of the California Department of Health Services (DHS) that became effective on January 1, 2004. The ratios cannot be met in many psychiatric units and several hospitals have been forced to reduce capacity, close units, and in some instances, close entire facilities. This disturbing trend will place greater pressure on access to services for patients with mental illness.

HHS11

Use Technology to Promote Ease of Use and Improve Efficiency in the Women, Infants and Children Supplemental Nutrition Program

CHA supports the automation of the Women, Infants and Children Supplement Nutrition Program (WIC.) Implementation of an electronic benefits process should decrease administrative costs and improve security and freedom of choice for WIC recipients. This will allow WIC to achieve its mission of promoting proper nutrition as a way to decrease the risk of poor birth outcomes and improve the health of children during critical times of growth and development.

HHS15

Consolidate the State's Mental Health and Alcohol and Drug Programs to Better Serve Californians

CHA concurs with the rationale for establishing a Behavioral Health functional area within the new Health and Human Services Department (HHSD) and consolidating health programs currently being provided by both the Department of Mental Health and the Department of Alcohol and Drugs. The current fragmentation of two separate and

unconnected departments creates significant confusion for providers of services and consumers, and may actually compound the problems associated with relapse rates.

Integrated treatment is the preferred option for persons with mental illness and substance-abuse disorders. However, consolidation of these two departments will only be successful if consideration is given to the unique clinical strategies and values from each field.

HHS 17

City-Level Mental Health Programs Are Outdated, Inconsistent With Laws

CHA supports the recommendation to eliminate the city-level mental health programs and reallocate those responsibilities and funds to the respective counties. In doing so, this will promote better coordination and integration of policy and programs for all county-based mental health services. Our only concern would be the existence of appropriate infrastructures to facilitate a move of this nature. Neither consumers nor providers of services should be adversely impacted by a blending of these programs, and adequate safeguards must be in place to ensure this does not occur.

HHS 19

Standardize Criminal Background Reviews in Health and Human Services Agency

CHA supports standardized background checks for direct caregivers in healthcare facilities provided that the process is completed in an effective, efficient and timely manner. Patients should be secure with a reasonable assurance that the people taking care of them do not possess criminal intent. CHA agrees that criminal background clearance of health and human services caregivers is an area of law that suffers from a lack of coordination. Laws have been implemented on a piecemeal basis, focusing on the location in which the caregiver will provide services rather than a broader public policy. The specific crimes at issue, as well as the clearance process, are not consistent. In addition to coordinating the standards, we strongly recommend that the state consolidate and streamline the criminal clearance process. Background checks should be conducted on a timely basis. Otherwise any changes in this area pose the likely potential of exacerbating the workforce shortage and thereby negatively impacting service delivery and access.

HHS 21

Consolidate Licensing and Certification Functions

CHA supports consolidation of licensing and certification functions to some extent. Specifically, when the knowledge and skill base of the oversight personnel is very similar, we strongly support consolidation. For example, the Board of Registered Nursing and the Board of Vocational Nursing and Psychiatric Technicians are two boards that could be consolidated without any loss of technical expertise. Combining all licensing and certification functions impacting health care and community care within the state, however,

will not necessarily improve efficiency or effectiveness. History shows that simply because a surveyor is proficient at surveying a skilled-nursing facility, it does not mean that the surveyor has the knowledge or skills to survey a hospital. The relevant regulations and the standard procedures for doing business vary significantly between the two settings. Any consolidation would require maintenance of appropriate expertise.

HHS 22

Issue Fee-Supported Licenses Without Delay

CHA supports reducing the backlogs and processing times for licensing and certification of health care personnel and facilities. This backlog exacerbates the workforce shortage and serves as a barrier to patients' access to services. In lieu of the specific recommendations set forth in the CPR report, CHA recommends that DHS reduce its workload in appropriate areas. Specifically, hospitals that are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) should have deemed status, thus reducing DHS' role and staffing in the regular survey process.

HHS 23

Streamline Oversight Requirements for Conducting Medical Survey/Audits of Health Plans

CHA supports streamlining medical survey/health plan audits. There is considerable overlap in the oversight responsibilities of the Department of Managed Health Care (DMHC), DHS and the Managed Risk Medical Insurance Board, and it creates unnecessary administrative and financial burdens for the health plans that participate in two or more of these programs. However, DHS is responsible for a population that differs from the population covered by commercial health plans. Generally Medi-Cal beneficiaries have social needs that affect health needs and without ensuring appropriate networks are in place, access to care could be compromised. Another concern is that some plans (county organized health systems) that are not Knox-Keene licensed are therefore not regulated by DMHC. This could be addressed, as outlined in the recommendation, by a memorandum of understanding.

CHA believes this idea has merit if the special needs of Medi-Cal beneficiaries, plans and providers are all considered and addressed.

HHS 26

Maximize Federal Funding by Shifting Medi-Cal Costs to Medicare

CHA supports the state maximizing federal funds available to California. As outlined in the recommendations, Medi-Cal beneficiaries eligible for Medicare should be enrolled in Medicare with Medi-Cal then acting as the secondary rather than primary payer.

HHS 27

Automate Identification of Other Health Coverage for Medi-Cal Beneficiaries

CHA supports the recommendations contained in this section. Ensuring Medi-Cal beneficiaries who have other health coverage receive the benefits provided by that coverage will improve access to care for these individuals.

Checking a beneficiary's eligibility in other health plans would be most effective if California and all California health plans had fully implemented the transactions and code sets of the Health Insurance Portability and Accountability Act (HIPAA). These eligibility transactions could be performed routinely and electronically, rather than the laborious paper, phone or legacy system that is in place today.

HHS 28

Improve Integrity in Medi-Cal Through the Use of Smart Cards

CHA supports the concept behind the use of smart cards as a vehicle to reduce fraud and abuse in the Medi-Cal program. With limited Medi-Cal funds available, legitimate providers are clearly disadvantaged when fraudulent providers bill the program inappropriately.

CHA believes this issue requires further study. Legitimate providers that deliver appropriate health care services to Medi-Cal beneficiaries should not be penalized or required to perform unnecessary administrative duties for Medicaid payments that are the lowest in the nation. Our members report that Medi-Cal beneficiaries arrive in hospitals without their beneficiary identification cards far more often than with their beneficiary identification cards. Additionally, hospitals go to great expense to enroll eligible individuals in Medi-Cal at the time the hospital services are provided. This requires the hospital to then bill Medi-Cal retroactively. In both of these instances, an identification card is not available at the time of service. Since neither of these instances is fraudulent, the hospital must be able to continue to bill Medi-Cal for the services provided without undue administrative burdens.

HHS 29

Redirect Medi-Cal Hospital Disproportionate-Share Payments

The disproportionate-share hospital (DSH) program allows qualifying hospitals to receive supplemental Medicaid (Medi-Cal) payments to help address the shortfalls created by caring for high volumes of medically needy, under- and uninsured patients. The DSH designation is shared by a select number of qualifying public, private, university, district and children's hospitals. California has the most stringent qualifying criteria in the nation for participation in the DSH program.

The recommendation of CPR HHS 29 is to redirect Medi-Cal hospital DSH payments from hospitals that do not provide "desirable core hospital services," which are cited as neonatal intensive-care services, emergency services and obstetrical services, or hospitals that are not developing credible plans to meet seismic-safety requirements. This recommendation requiring DSH hospitals to meet limited "core" criteria to receive DSH funding would damage the existing health care safety net and compromise access to care.

First, the federal DSH program is predicated upon the need for supplemental funding for hospitals to offset losses incurred as a result of their overall level of services to low-income and uninsured patients. Funding is based on their high proportion of acute-care services, not upon which services are provided. One of the reasons DSH eligibility and funding are predicated on the percentage of care devoted to low-income patients, rather than on types of services, is that different communities have differing "core needs." In many communities, it may be more important to provide a full range of services, rather than the services defined as "core" services in the CPR. Similarly, communities with high levels of seniors may be less dependent on OB and NICU services from safety-net providers, but are in greater need of emergency services or cardiac/pulmonary-care units. In other communities, there may be more than one safety-net hospital serving the population, and duplication of certain services may not be necessary or appropriate. Acute-care hospitals that provide essential health care services to large volumes of Medi-Cal and uninsured patients are the cornerstone of the state's safety-net system. The elimination of DSH funding to existing safety-net hospitals would threaten the fiscal viability of the hospitals and result in potential hospital closures or service reductions.

A small number of essential inner-city hospitals that lose money each year provide a broad range of services, including specialized services such as trauma care, obstetrical care, neonatal intensive care, etc. They are disadvantaged under the current system and steps are being explored to ensure that additional funding is made available to them. These hospitals cannot survive over the long term and supplemental payments must be made available to preserve access to hospital services for many low-income patients.

CHA is concerned about tying DSH funding to meeting seismic-safety requirements. The Legislature has established specific unfunded seismic mandates and deadlines that are applicable to all hospitals. DSH funding is meant to provide operating support to ensure the continued availability of medically necessary health care services. Funding to assist hospitals must be provided for hospitals to comply with the seismic-safety law. Seismic-safety is a broader issue than DSH.

HHS 30

Centralize Medi-Cal Treatment Authorization Process

CHA does not believe the recommendation to restructure the Medi-Cal treatment authorization (TAR) process to one or two centralized locations will reduce the variation in medical determinations that currently plague the medical review process. In spite of the widespread use of evidence-based clinical standards and guidelines throughout the health

care industry, the Medi-Cal fee-for-service system operates without basic medical standards and guidelines to support consistent adjudication of the routine to the most complex requests for medical services. As a result, the field office staff does not receive basic tools and training to perform their review and adjudication responsibilities in a consistent, objective manner. Consequently, providers and their patients are subjected to repeated delays of medically necessary services as providers satisfy the requests for additional documentation or submit requests through the provider appeal process.

Medi-Cal often takes longer than other payers — including some commercial HMOs that have a poor reputation in this regard — to pay its providers after services are rendered that require TARs. Furthermore, the state often does not process these "pre-treatment" requests until well after services are provided, thus making the process ineffective at containing costs or tracking utilization. Coupled with Medi-Cal's inadequate provider reimbursement (the lowest in the nation), these delays further reduce reimbursement, negatively impacting hospitals. This directly affects access to care for Medi-Cal beneficiaries. In an era of decreasing reimbursement, CHA is pleased to see the state considering options to reduce administrative burdens and unnecessary payment delays, thereby increasing funding available for patient care.

However, CHA believes the recommendations contained in the CPR report do not get to the core of this problematic issue, and merely modify an ineffective and inadequate system. Medi-Cal should consider the efforts to reduce fraud and utilization review used by both Medicare and commercial health plans, and use similar tools rather than merely modifying the current ineffective system of TARs.

CHA instead recommends agency review other recommendations to streamline TARs, including:

1. Reduce the number of TARs required by conducting sampling and using treatment plans and other industry standards. Change the review from pre- to post-payment.

2. Develop a standard set of adjudication guidelines rather than using the arbitrary application of current ambiguous and out-of-date Medi-Cal medical necessity criteria.

3. Develop alternative review processes for fraud and abuse detection, such as the use of sophisticated claims algorithms.

4. For TARs that are required, ensure each TAR is cost-effective.

The recommendation to automate TARs requires more consideration. For many years, an effort to bring e-TAR to providers has been in process. However, despite a tremendous expenditure of time and resources, this has not come to fruition. Additionally, the current e-TAR system is not HIPAA-compliant. Implementing a system unique to Medi-Cal flies in the face of the goals of standardization contained in HIPAA.

CHA reiterates the need to consider ideas beyond merely modifying an already "broken" TARs system.

HHS 31

Medi-Cal Fraud Targeting Misses Mark

CHA supports the recommendations to reduce fraud in the Medi-Cal program. However, we urge thoughtful consideration be given before any changes are implemented that could result in administrative burdens for legitimate providers participating in the Medi-Cal program delivering care to beneficiaries. There are, at best, a limited number of providers willing to deliver care for the Medi-Cal reimbursement provided and this currently compromises access to care for beneficiaries. Additional administrative "hoops" on top of already low reimbursement will further restrict access and ultimately cost the program additional dollars due to individuals seeking primary care in hospital emergency departments.

HHS 33

Eliminate Dual Capitation for Medicare/Medi-Cal Managed Care Plans

CHA recommends further study on this issue prior to making any changes. Rates paid to Medi-Cal managed care plans are already notoriously low and reducing them further — even for this seemingly common sense reason — could compromise access to care for the beneficiaries enrolled in these plans.

Additionally, all county organized health systems (COHS) are experiencing significant financial struggles. This can be attributed to a number of reasons, but the capitation payments paid by the state are at the top of the list. COHS, more so than the other Medi-Cal managed care models, should be examined closely prior to making any changes in payments. These plans currently have the responsibility for the aged, blind and disabled (ABD), and likely the increased costs associated with caring for these individuals — even if only limited services are required due to Medicare coverage — has contributed to their financial vulnerability.

Transferring Functions of the Department of Managed Health Care to HHS

(There is no specific CPR recommendation number assigned to this issue. The issue, however, is referenced in Volume II of the CPR report, Chapter 2, "The Department of Health and Human Services, Proposed Organization Improvements.")

CPR recommends eliminating DMHC as a separate department (currently housed within the Business, Transportation on Housing Agency). Under CPR's proposal, the licensing functions of DMHC would transfer to the new Quality Assurance Division within HHSD, while the administrative functions would transfer to the Office of the Secretary at HHSD.

However, the organizational charts indicate DMHC functions would be transferred to the Quality Assurance Division within HHSD.

Since the proposal to transfer the functions of DMHC to HHSD is not a specific recommendation, we are unclear as to the specific nature of the recommendation. Generally, moving DMHC to HHSD will achieve the goals of CPR because DMHC will be part of a larger "super department" focused solely on the health care system.

At present, DMHC is located within the Business, Transportation and Housing Agency (BTH). With the advent of managed care in California, legislators and regulators focused their regulatory efforts on ensuring the solvency of health plans. Accordingly, it was appropriate to place jurisdiction over health plans within the Department of Corporations at BTH. However, as the Knox-Keene Act developed over the years, an increasing emphasis has been placed on quality of care and consumer issues. As a result, DMHC was created in 1999 as a separate entity within BTH to focus exclusively on the regulation of managed health care.

CHA believes, however, that this proposal will only improve access, outcomes and efficient regulation if programs within DMHC are transferred intact to HHSD. It may even be advisable to maintain DMHC as a department within HHSD since most of the functions involving the regulation of managed health care plans are unique and not easily and efficiently transferable to other organizations within HHSD.

DMHC has been functioning as a separate department for four years, and has accomplished much in that short period of time. Only now is DMHC developing a system to enforce the prompt and fair payment requirements of the Knox-Keene Act, an issue of critical importance to hospitals. It is imperative that this new program remain fully functional, regardless of the organizational structure that is implemented.

Center for Public Health Environmental Programs

(Volume II, Chapter 2, C. Center for Public Health, pg. 15 states under 3. Transferred Functions that the current public and environmental health programs from the Department of Health Services in the current Health and Human Services Agency should be the nucleus of this new public health effort.)

CHA concurs with this recommendation. CHA also believes that the proposed Center for Public Health is enhanced by the addition of the functions of the Office of Environmental Health Hazards Assessment (OEHHA) currently based within the California Environmental Protection Agency (EPA). CHA believes that placing OEHHA in the proposed Public Health Division, within the HHSD, will enhance the state's public health function. OEHHA currently provides toxicological and medical information to public health. Therefore, placing OEHHA in the Public Health Division would result in coordinated and improved outcomes. The service provider/public health network will benefit, as well as all Californians who benefit from the state/county/local public health network. The bene-

fits will result from coordinated priority setting and policy development and efficiencies from better communications and economies of scale.

Medical Waste/Radiological Health

It is ironic that two programs that have strong public health implications — Medical Waste Program and Radiological Health Branch — are scheduled to be removed from the existing Health and Human Services Agency and relocated into Cal EPA or its successor. CHA is opposed to the relocation of these two programs as addressed below.

Medical Waste

The vast majority of medical waste is generated in health care facilities. Historically, the two entities that interface most with the DHS Medical Waste Program are two entities that are being retained in HHSD — licensing and public health. Unfortunately, the Medical Waste Program is proposed to move to Cal EPA.

The focus of dealing with waste-generation problems and waste-treatment problems under the Cal EPA is through a regulatory focus. This includes closing sites and pulling licenses. This approach is needed to ensure the environment and the public is protected.

Due to the fact that hospitals need to remain open to serve their communities and medical waste is a natural result of providing health care services, the DHS Medical Waste Program's focus is on protecting patients rather than stopping the generation and treatment of waste.

In doing so, the Medical Waste Program has a close working relationship with licensing. Medical Waste Program staff understands hospitals. During inspections, they educate hospital staff on how other hospitals have successfully dealt with medical waste issues.

As the national focus on building "Green Hospitals" has evolved, Medical Waste Program staff has become knowledgeable of Green Hospital Programs and trends, and shares this information with environmental service managers at hospitals. The DHS Medical Waste Program played a major role in legislation for sharps-injury prevention, silver halide disposal and pharmaceutical waste disposal. Therefore, if the Medical Waste Program moves to Cal EPA or its successor, CHA perceives that patients, public health programs and generators of medical waste will be affected in a negative manner due to:

- A substantial decrease in coordination among the Medical Waste Program, licensing and public health.

- A negative impact on service providers due to Cal EPA not having a background in health care facilities.

Radiological Health Branch

CHA is well aware of the politics of radioactive waste and the mission of some environmental groups to make California nuclear free. Because the Radiological Health Branch has a history of being fair and basing its decisions on science rather than hysteria, there has been a move for some time by some environmentalists to move the Radiological Health Branch out of DHS and into Cal EPA.

The DHS Radiological Health Branch coordinates its activities with the Nuclear Regulatory Commission (NRC). NRC is the federal entity that has radiological health expertise. The U.S. Environmental Protection Agency (EPA), which has no health physicists, attempts to establish safe levels of radiological exposure at levels below radioactive detectability. The U.S. EPA formula is based on the Comprehensive Environment Response, Compensation and Liability Act of 1980 (CERCLA). CERCLA is used for the cleanup of Superfund Sites and is not intended to be used for the regulation of radiological activities.

Over the past couple of years, environmental groups in California have attempted to mandate CERCLA criteria on Radiological Health Branch activities. If the Radiological Health Branch is not placed in the Public Health Division of the proposed HHSD, CHA perceives that Cal EPA or its successor, will adopt the U.S. EPA CERCLA standard. This would have a negative affect on radiological and nuclear medicine diagnostic and treatment procedures. The CERCLA standards are so unrealistic that it would eventually mean the demise of radiological health research in California and result in pharmaceutical companies that produce radioisotopes leaving the state. Since many nuclear medicine staff at California hospitals and medical centers serve as consultants to pharmaceutical manufacturers, pharmaceutical manufacturers leaving the state will impact access to quality nuclear medicine services in California.

Facilities Development Division

CHA was invited by the CPR Commission to comment on the current OSHPD Facilities Development Division (FDD) at the infrastructure public hearing on August 13 in Riverside. Please find attached a copy of the CHA's testimony. CHA is sharing this testimony with the Health and Human Services Agency because CHA believes that FDD should be located in the proposed HHSD Quality Assurance Division and be aligned with licensing. CHA believes the alignment of FDD and licensing is essential for ensuring coordination, efficiency and quality plan review, area compliance and licensing outcomes.

Change in California Medical Assistance Commission

(There is no specific CPR recommendation, however the issue is referenced in Volume II of the CPR Report, Chapter 2, "The Department of Health and Human Services Proposed Organization Improvements.")

CPR recommends eliminating the California Medical Assistance Commission (CMAC) as a separate entity and including it in the HHSD, Health Purchasing Division.

Since the proposal to transfer the functions of CMAC to the new Health and Human Services Department (HHSD) is not a specific recommendation, CHA is unclear as to the specific nature of the recommendation.

At present, CMAC is responsible for negotiating contracts with hospitals to provide inpatient services to Medi-Cal beneficiaries. However, the current federal waiver that provides for hospital contracting is part of the proposed redesign of safety-net hospital financing. Therefore, it is possible that the functions of CMAC, if not its existence, may be substantially changed.

CMAC was established as an independent commission as part of the implementation of the Selective Provider Contracting Program (SPCP). An important CMAC role is to help ensure access to hospital services for Medi-Cal beneficiaries across the state. Through a competitive negotiating process, CMAC has been effective over the last 20 years in ensuring that there is appropriate capacity in local markets to meet the hospital needs of Medi-Cal beneficiaries.

CMAC's role as an independent negotiating body has been critical to fulfilling its functions. Because of the selective and competitive nature of the SPCP in setting Medi-Cal inpatient rates, it is critical that the negotiator of rates be independent from the payer of those rates in order to help ensure access to services for Medi-Cal beneficiaries. If there is no insulation between the negotiating and payer functions, inpatient hospital rates may be driven by more narrow fiscal concerns, potentially without sufficient consideration of critical access standards.

CHA also notes that there appears to be an inconsistency in this recommendation. While there is a recommendation to eliminate CMAC, another separate recommendation gives CMAC additional authority. These inconsistencies should be addressed prior to implementing or even considering changes as recommended in the CPR report.

CHA urges careful review of the proposed redesign of safety-net hospital financing and the impact on various entities, including CMAC, prior to making any changes in this complex and fragile system.

CPR, Oversight of LEMSAs

CHA supports the CPR's reorganization proposal that would place the Emergency Medical Services Agency (EMSA) in the Public Safety and Homeland Security Department.

We would also suggest a reorganization of the management and supervisory relationship between EMSA and the Local Emergency Medical Services Agencies (LEMSA). Currently, each LEMSA functions on its own with little oversight or coordination by any

other agency. As an example, a few years ago, it took several hours to even identify the responsible person at each LEMSA. We suggest that in order to provide quality, coordinated and standardized pre-hospital care services throughout California, EMSA be responsible for, at a minimum, overseeing the quality of care provided by LEMSAs.

Conclusion

CHA appreciates the CPR recommendations regarding health and human services. We look forward to working with you, CHHSA, and other stakeholders as these proposals are further developed.

Attachment